COLUMBIANA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
SERVICE AND SUPPORT ADMINISTRATION
35947 ST. RTE. 172
LISBON, OHIO 44432
330-424-0404 ext 164/FAX 330-424-1184

Individual's Name:
Contact person:
Address:

The above individual was referred for Developmental Disabilities services in our county. To begin services in our county we will need the following documents to prepare for the OEDI/COEDI or transfer process:

1. The completed **referral form** from the attached Intake packet
2. ***Submit documents or sign release(s)*** to obtain ***verification documents*** regarding **diagnoses**, **severity** of diagnoses and **need for individualized services** prior to age 22 and current needs (physicians, psychologist, schools, hospitals…)
3. **Submit test results or sign release(s) to obtain** documents ***current within 1 year and prior to age 22*** of a **medical evaluation** and a **psychological evaluation** including all subtest results, narrative, DSM IV codes and Axis report.

Copies of all the documents listed below:

Birth certificate	**Medicaid card**
Social Security card	**Medicare Card**
Photo ID or recent Photo	**Guardianship papers**
Court restrictions **Any court or jail records** **Probation restrictions**	

If services had been given in anther Ohio County for Developmental Disabilities submit the following information as well:

• Name/ contact information of current/previous **Service Support Administrator** • **Waiver** allocation & ODDP score ***or*** Waiver **Waiting List** information	**Complete/signed/dated ODDD forms/assessments:** • Pre-screen tool • Functional assessment • Freedom of Choice	• OEDI/COEDI with FED/CFED • ***Verification documents of qualifying diagnosis prior to age 22*** • IEP or ISP • Behavior Support plans • NICS indicating transfer
Complete list of **medications** including: • **Physician** who prescribed them and **ID number** for refill • Number of **refills** remaining and the **number of doses on hand** to be transferred • **Pharmacy c**ontact information for transfer to local pharmacy		**Bank records including:** • Account numbers to transfer funds to a local facility if applicable • Representative payee contact • Copies of award letters (SS/Food Stamp) **Copy of Life Insurance policy & burial arrangements**
You may submit any other information that you wish to support your case for eligibility for services with our agency including the names and contact information of persons who know the individual well that could give input regarding their needs and abilities.		

Once the requested documents are received and reviewed you will be notified concerning testing for eligibility for services or transfer into our county. If you have any questions please feel free to call me Monday through Friday (8:00 AM – 4:00 PM).

Patricia E. Homan,
Service Support Administrator/Intake & Waiver Coordinator

COLUMBIANA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

REFERRAL FORM

TO REFERRAL SOURCE: *To refer an individual for services of the Columbiana County Board of Developmental Disabilities, please complete this form.*

Date this form completed: _____ Social Security Number: _____

Name of Referral: _____☐ own guardian Telephone: _____

Date of birth: _____ Age: _____ ☐ Male ☐ Female ☐Medicaid ☐Medicare

☐ Caregiver ☐ Court appointed Guardian ☐ POA ☐ Custodial Guardian _____

Present Address: _____

Do you currently live in Columbiana County? ☐Yes ☐ No Have you moved within the last year? ☐ Yes ☐No

If "Yes" list previous address: _____

Referred by:

Name: _____

Agency (if applicable): _____

Address: _____

Telephone Number: _____ Fax Number: _____

What service(s) does this individual need? Check all that apply:

☐ Children's service ☐ Adult Services ☒ Family Service & Support

☐ Residential Services ☐Service & Support Administration

Was the individual least age 18 years old and eligible for and enrolled in an Ohio County Board of Developmental Disabilities Program on July 1, 1991 (Grandfather status)? ☐ Yes ☐No If yes, what county? _____

Did you receiver any DD services in any other county? ☐ Yes ☐No If yes, what county? _____

What services did you receive? ☐ Early Intervention ☐ School ☐ Workshop ☐ Residential ☐ SSA

Individual's disabilities as reported by informant: _____

_____

Does the Individual have physical or mental impairments other than mental illness that may be a qualifying diagnosis?
☒ Yes ☐No If yes, please list: _____

_____

Did the individual's qualifying diagnosis disability occur before age twenty-two? ☐ Yes ☐No

Is the individual's qualifying disability likely to continue indefinitely? ☐Yes ☐No

What agencies/physicians/psychologists/hospitals are currently or have provided services that can both verify each diagnoses and severity of the diagnoses prior to age 22 and now?

Agency/Physician/Hospital	Address	Phone	Fax

Medication Name Date Filled	Dose	Frequency	Prescribing Physician	Related Diagnosis or Condition

EDUCATION:

Elementary School - Name: _____

Address: _____

Phone: _____Fax: _____

High School - Name: _____

Address: _____

Phone: _____Fax: _____

Dates Attended: _____ Graduated: ☐ Yes ☐ No G.E.D.: ☐ Yes ☐ No

VOCATIONAL TRAINING IN ADDITION TO ABOVE EDUCATION: ☐ Yes ☐ No

EMPLOYMENT HISTORY: ☐ Yes ☐No

Name of Employer/Address/Phone	Job(s) performed	Years of employment

PLEASE SUBMIT COPIES OF:

Birth certificate	Medicaid card
Social Security card	Medicare Card
Photo ID or recent Photo	Guardianship papers

SUBMIT REFERRAL TO: SSA Office- Intake Department
35947 State Route 172
Lisbon, Ohio 44432

FOR CCBDD USE ONLY

_____

Superintendent's Signature **Date**

Updated 01/13/2014 peh

Columbiana County Board of Developmental Disabilities
35947 State Route 172
Lisbon, Ohio 44432
PHONE: (330) 424-0404
FAX: (330) 424-1184

CONSENT TO TEST

I: _____
Parent/Guardian Name

Give my consent for an SSA representing Columbiana County Board of Developmental Disabilities to administer the
Children's Ohio Eligibility Determination Instrument (C/OEDI) ages 6-16 or Ohio Eligibility Determination Instrument (OEDI) ages 16 or older to:

_____
Individual's Name

To determine eligibility for Developmental Disabilities services and /or assistance where needed.
I understand that I may invite informants of my choice who could offer information or explanation that may be helpful to the tester in making a determination.

☐ I have read this Authorization or it has been explained to me.

☐ I have received a copy of the Columbiana County Board of Developmental Disabilities Notice of Privacy Practices – Effective April 14, 2003

☐ I was offered an opportunity to register to vote.

In compliance with policies and procedures of confidentiality pursuant to Rule 3301-52-02 of the Administrative Code and 34 CFR Regulation 99.3.

_____ _____
Signature of Client or Guardian **Date**

_____ _____
Signature of Guardian: **Date**

_____ _____
Witness Signature **Date**

Ohio Department of Job and Family Services/Columbiana County Board of Developmental Disabilities

VOTER REGISTRATION
NOTICE OF RIGHTS AND DECLINATION

County Department of Job and Family Services: COLUMBIANA	
Name:	**Date:**

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ YES, I want to register to vote or update my voter registration today
☐ No, I do not want to register to vote today
☐ I am currently registered to vote and my registration information is current and accurate
☐ I am not eligible to vote due to court determination of incompetency, I am underage or I am not a citizen

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Signature:	**Name of CCBDD individual assisting you today:** Patricia E. Homan, SSA

(This portion to be retained by agency)

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(This portion to be given to applicant/recipient)

Date:

If you have not received any verification of your voter registration from the county board of elections in which you reside within 21 days from the date you registered, you may inquire about the status of your registration by contacting your county board of elections. (*7989 Dickey Drive Suite 3, Lisbon, Ohio 44432-8394*-----330-424-1448)

If you think that someone has interfered with your right to register or decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or political preference, you may file a complaint with the prosecuting attorney of your county or with the Secretary of State:

Ohio Secretary of State
180 East Broad Street
Columbus, Ohio 43125
(616) 466-2585
Toll Free: (877) 868-3874

County Prosecutor: Robert Herron
Address of County Prosecutor: **105 South Market Street, Lisbon, Ohio 44432-1295**
Phone Number of County Prosecutor: 330-424-6677

Notice of Privacy Practices

Columbiana County Board of Developmental Disabilities

FOR YOUR PROTECTION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. It also describes our practices about Robert Bycroft School records.

YOUR RECORDS ARE PRIVATE

We understand that information we collect about you or your child and records of the services and supports we provide, are personal. Keeping these records private is one of our most important responsibilities. The Board must follow many laws to protect your privacy. For the Robert Bycroft School records, we follow the federal FERPA laws. For adult services, and certain services for children, we follow the federal HIPAA laws. In addition, we follow many laws specific to Ohio Department of Developmental Disabilities Boards. For this notice, we will use the term "records" to mean the paper or electronic records we maintain about you.

Your records may be used and disclosed by the employees and volunteers at the Board who serve you, as well as persons or agencies who work for us and sign strict confidentiality contracts.

Our organization includes [Robert Bycroft School] [Adult Senior Center] [EDI Central] [EDI South] [Beaver Creek Candle Co.] [SSA Department] [Transportation Department] [CCBDD Administration] [Service Coordination] [Adult Services] [Residential] [Early Intervention].

At Robert Bycroft School, for example, records may be shared with "school officials" who have a "legitimate educational interest" in your child. "Educational interest" means any matter related to your child's instruction, developmental or behavioral support, dietary, health or safety. "School officials" include teachers, paraprofessionals, aides, bus drivers and administrators at Columbiana County Board of Developmental Disabilities.

WHO USES AND DISCLOSES MY RECORDS?

In general, we use and disclose your information:

- For teaching, behavioral and medical support, transportation and school administration. For example, a school administer will review progress data created by teachers.
- To provide the full range of services we provide: early intervention, habilitation, supported employment, and other services. For example, your service and support administrator will review your records to create an individual service plan, which may be shared with you, your guardian, and other individuals involved with providing services and supports to you.
- To get payment for services provided,
- For other operations to operate and manage the board: these include improving quality of care, training staff, managing costs, and conducting other business duties. For example, a quality assurance reviewer may audit your records to determine whether appropriate services were provided, and
- To remind you or a guardian of an appointment for services.

COULD MY RECORDS BE RELEASED WITHOUT MY PERMISSION?

There are limited situations when we are permitted or required to disclose your records, or parts of them, without your signed permission. These situations include:

- Record transfers to other schools your child enrolls in,
- Reports to public health authorities to prevent or control disease or other public health activities,
- To protect victims of abuse, neglect, or domestic violence,
- For oversight including investigations, audits, accreditation and inspections, such as are conducted by the Ohio Department of Developmental Disabilities and federal agencies,
- When a court order, subpoena or other legal process compels us to release information,
- Reports to law enforcement agencies when reporting suspected crimes, when responding to an emergency, or in other situations when we are legally required to cooperate,
- In connection with an emergency, or to reduce or prevent serious threat to public health and safety,
- To coroners, medical examiners and funeral directors,
- To victims of alleged violence or sex offenses,
- For workers' compensation programs,
- For specialized government functions including national security, protecting the president, operating government benefit programs, and caring for prisoners,
- In connection with "whistleblowing" by an employee of the Board.

All other uses not described above require that we obtain your signed permission.

WHAT IF MY RECORDS NEED TO GO SOMEWHERE ELSE

For any purpose not described above, we will release your information only with your explicit written authorization. Federal law requires the that we notify you that any healthcare provider must obtain your explicit permission to release your information for any of the following:

1. Psychotherapy Notes will only be released with your signed authorization;
2. For marketing purposes;
3. To sell information about you.

It has never been the board's practice to release information for marketing purposes or to sell your information. Your written authorization tells us what, where, why and to whom the information must be sent. Your signed authorization is good until the expiration date you specify. You can cancel your permission at any time by letting us know in writing.

WHAT ARE MY RIGHTS REGARDING PRIVACY, ACCESS TO MY RECORDS, AND THE ACCURACY OF MY RECORDS?

You have legal rights concerning your privacy, access to your records, and the accuracy of your records. You have the following rights:

1. To see your records, or to get a copy, including an electronic copy;
2. To request a correction to your records if you believe they are incorrect;
3. To receive all communications at a confidential address or phone number;
4. To receive an "accounting of disclosures", that is, a list of any place we sent your record without your authorization;
5. To request additional limits on how we use or disclose your information, although we are not obliged to honor these requests except that if you choose to personally pay for services delivered, we will not bill Medicaid.
6. You may receive a paper copy of this notice.

To exercise any of these rights, or if you have any questions or complaints regarding our privacy practices, call, deliver, mail or email your request to:

HIPAA Compliancy Officer
Columbiana County Board of DD
7675 State Route 45
Lisbon, OH 44432
(330) 424-7788
ccbdd@spii.net

Ask any employee if you need help in putting your request in writing.

OUR DUTIES

We are obligated by law to maintain the privacy of your information and to provide this notice. In the event of a breach, that is, an improper disclosure of your information, we are required to notify you. We are required by law to abide by the terms of this notice. From time to time we may make changes to our policies, and if and when we do, your records will be protected by our new, changed policies. Our current notice will always be available on our website.

QUESTIONS OR COMPLAINTS?

If you have any questions or complaints about our privacy practices, please contact us:

Attn: HIPAA Compliancy Officer
Columbiana County Board of DD
7675 State Route 45
Lisbon, OH 44432
(330) 424-7788

We will never retaliate against you for filing a complaint. Further, if you are not satisfied with the results, you may also complain to the federal government:

For School issues:
Family Policy Compliance Office
U.S. Department of Education
400 Maryland Avenue, SW
Washington, D.C. 20202

For any other issues:
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Original Notice effective 4/14/2002; Current Revision effective 7/1/2013.

Columbiana County Board of Developmental Disabilities (CCBDD) – Authorization Form

Columbiana County Board of DD
7675 State Route 45
Lisbon, OH 44432
330-424-7788

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name of Individual Served _____ Date of Birth _____

I authorize CCBDD to:

Release to: _____

The following information:
___ Assessment and diagnosis (MFE)
___ Treatment and progress
___ Social History
___ Psychological Test results
___ Other _____

Obtain from: _____

The following information:
___ Assessment and diagnosis (MFE) (F.E.D.)
X__ Treatment and progress
___ Most current IP (ISP, IEP, IHP)
___ Psychological Test results
X__ Results of recent physical examination
X_ Other _Include medications list with frequency, dose, purpose; list diagnoses

The purpose of this disclosure is
___ Coordination of care
___ Requested by Individual Receiving Services, or guardian/parent
___ Other _____

1) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
2) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
3) The CCBDD does not require that I sign this authorization in order to receive services.

Expiration Date:
___ 90 days from date signed
___ other date: _____

Approved by: _____ Date: _____
If signed by someone other than the Individual being served:

Print Name: _____
Authority to sign: ____ Parent or Guardian
____ Appointed by Individual as HIPAA Personal Representative
____ Other _____

For staff use (complete the following steps and indicate by a check. Name of Staff Person _____)
___ Copy of signed authorization given to Individual / Parent / Guardian
___ Copy of records released given to individual / Parent / Guardian (if requested)
___ Disclosure logged on Disclosure Log
___ Revocation received on _____ and acted upon.

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___ Assessment and diagnosis (MFE) (F.E.D.)
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___ Requested by Individual Receiving Services, or guardian/parent
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___ Other _____

Obtain from: _____

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The purpose of this disclosure is
___ Coordination of care
___ Requested by Individual Receiving Services, or guardian/parent
___ Other _____

7) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
8) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
9) The CCBDD does not require that I sign this authorization in order to receive services.

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The following information:
___ Assessment and diagnosis (MFE) (F.E.D.)
___ Treatment and progress
___ Most current IP (ISP, IEP, IHP)
___ Psychological Test results
___ Results of recent physical examination
___ Other _____

The purpose of this disclosure is

___ Coordination of care
___ Requested by Individual Receiving Services, or guardian/parent
_X_ Other Eligibility determination for DD services

10) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
11) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
12) The CCBDD does not require that I sign this authorization in order to receive services.

Expiration Date:

_X_ 90 days from date signed
___ other date: _____

Approved by: _____ Date: _____

If signed by someone other than the Individual being served:

Print Name_____
Authority to sign: ___ Parent or Guardian
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___ Assessment and diagnosis (MFE) (F.E.D.)
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13) I understand that I may revoke this authorization at any time by submitting a written request, unless the records have already been released.
14) I understand that the party receiving my information might not be subject to HIPAA, FERPA or Ohio confidentiality laws and might be allowed to disclose this information.
15) The CCBDD does not require that I sign this authorization in order to receive services.

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